MassHealth

Billing Instructions for Paper Claim Form No. 10

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Introduction

The following information describes in detail how to bill on the paper claim form no. 10. For administrative and billing instructions, see Subchapter 5 of your MassHealth provider manual.

For information about the resulting remittance advice, see the Guide to Remittance Advice and Electronic Equivalents for Claim Form No. 10, available online at www.mass.gov/masshealth.

General Instructions for Submitting Paper Claims

Claim Form No. 10

All rest home and nursing facilities may use claim form no. 10 (Request for Payment- Long Term Care Facilities Claim) when submitting paper claims to MassHealth.

To obtain supplies of claim form no. 10, submit a request to MassHealth at the address found in Appendix A of your MassHealth provider manual.

Entering Information on Claim Form No. 10

Follow these guidelines when filling out the claim form.

- Type or print all applicable information on the claim form (as stated in the instructions), using black ink only. Be sure all entries are complete, accurate, and legible.
- Up to three separate entries can be made on a single claim form, including separate claims for the same member, or for different members. These entries can be made on lines A, B, and C.
- For each claim line, enter all required information as applicable, repeating if necessary. Do not use ditto marks or words such as "same as above."
- Attach any necessary reports or required forms to the claim form.
- When a required entry is a date, such as the date of service or the member's date of birth, enter the date in MMDDYY format.

  Example: For a member born on February 28, 1960, the entry would be as follows.

022860

Time Limitations on the Submission of Claims

The period fixed by statute (M.G.L. c. 118E, §20) for the submission of claims is 90 days, measured from the date of service or the date on the explanation of benefits (EOB) from another insurer to the date on which the claim form is received by MassHealth. For regulations governing time limitations on the submission of claims, see the billing regulations in Subchapter 3 of your MassHealth provider manual.

Since the 90-day requirement applies to each claim line, the claim form must be received within 90 days from the earliest date of service on the form.

General Instructions for Submitting Paper Claims (cont.)

For additional information about submitting claims, consult the administrative and billing instructions in Subchapter 5 of your MassHealth provider manual.

Claims for Members with Other Health Insurance Coverage

Special instructions for submitting claims for services furnished to members with health insurance coverage are contained in Subchapter 5 of your MassHealth provider manual.

Electronic Claims

To submit electronic claims, contact MassHealth Customer Service. Refer to Appendix A of your provider manual for contact information. Additional information is also available in Subchapter 5 of your provider manual.

Where to Send Paper Claim Forms

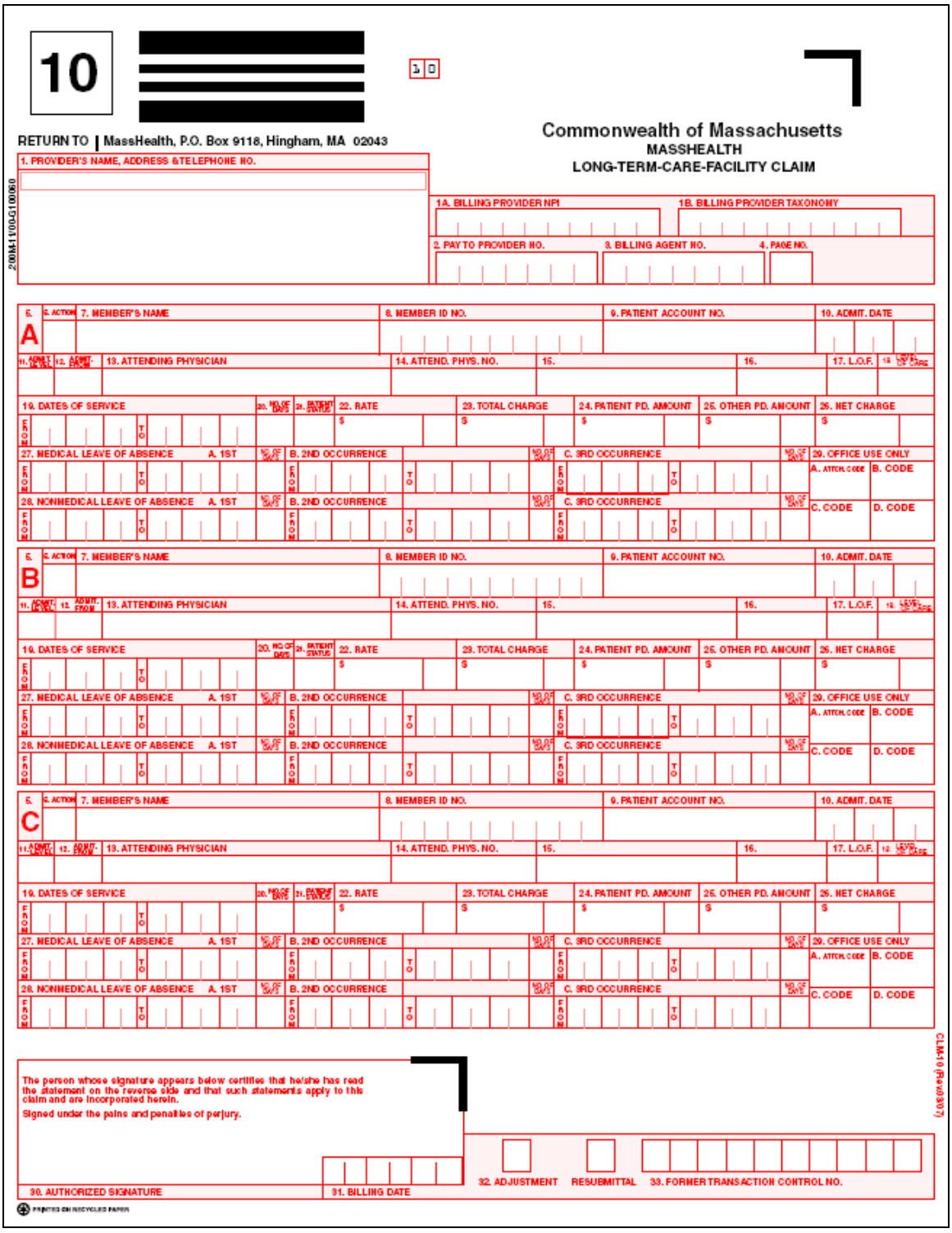
Appendix A of your MassHealth provider manual describes where to submit paper claims. Keep a copy of the submitted claim for your records. Please note that MassHealth does not accept mail with postage due.

Further Assistance

If, after reviewing the following item-by-item instructions, you need additional assistance to complete claim form no. 10, contact MassHealth Customer Service. Please refer to Appendix A for all MassHealth Customer Service contact information

Item-by-Item Instructions for Claim Form No. 10

A sample claim form is shown below. Following this sample are completion instructions for each field on claim form no. 10.



Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
1	Provider's Name, Address & Telephone No.	Enter the provider's name, address, and telephone number(s).
1A	Billing Provider NPI	Enter your billing (pay-to) NPI.
1B	Billing Provider Taxonomy	Enter the taxonomy code applicable for the billing (pay-to) NPI number only if instructed to do so by MassHealth.
2	Pay to Provider No.	Enter the provider's seven-digit MassHealth provider number or the group practice organization number, if applicable.
3	Billing Agent No.	If this form is prepared by a billing agent, enter the seven-digit number assigned to the agent. If one was not assigned, leave this item blank.
4	Page No.	Leave this item blank.
5	(Untitled)	Each letter (A-C) refers to one of the three claim lines on the claim form. This letter will appear as the last character of the claim's transaction control number (TCN) listed on the remittance advice (RA).
6	Action	For members continuing a stay, enter Action Code "I." For newly admitted members, enter Action Code "A."
7	Member's Name	Enter the name of the member receiving services.
8	Member ID No.	Enter the complete 10-character member identification number that is printed on the MassHealth card below or beside the member's name. The member ID on the temporary MassHealth card may include an asterisk as the 10th character.
9	Patient Account No.	Enter the patient account number, if one is assigned. If one is not assigned, enter the member's last name.
10	Admit. Date	Enter the date of the member's initial admission, or the date of the most recent readmission following a three-day hospital stay, to the facility in MMDDYY format.

Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
11	Admit. Level	Enter the code from the list below that describes the level of care assigned by the facility on the date of the member's initial admission. 3C – Rest home IV 3D – ICF geriatric III 3E – SNF geriatric II 3F – SNF-Medicare 3L – SNF pediatric II 3M – SNF psychiatric II 3R – ICF/MR type B 3S – ICF/MR type C 3U – SNF-Medicare I/II
12	Admit. From	Enter the code from the list below that describes the location from which the member entered the facility. 1 – Home or self-care 2 – Acute hospital 3 – Psychiatric hospital 4 – Chronic/rehabilitation hospital 5 – Skilled nursing facility 6 – Intermediate care facility 7 – Rest home 8 – ICF/MR community facility 9 – ICF/MR state school 10 – Community residence 99 – Other
13	Attending Physician	Enter the name of the attending physician if applicable.
14	Attend. Phys. No.	If an entry was made in Item 13, enter the MassHealth provider number of the attending physician. If this is not a MassHealth provider, enter "9999990."
15	(Untitled)	Leave this item blank.
16	(Untitled)	Leave this item blank.

Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
17	L.O.F. (Level of Functioning)	If the nursing facility is a case-mix provider, enter the code from the list below that describes the member's Management Minutes Category (MMC). The MMC codes represent the number of minutes per day spent by nursing services on case-mix management. MMC — Range of Minutes H — 0-30 J — 31-85 K — 85.1-110 L — 110.1-140 M — 140.1-170 N — 170.1-200 P — 200.1-225 R — 225.1-245 S — 245.1-270 T — 270.1+
18	Level of Care	Enter the code from the list below that describes the level of care the member is eligible to receive. 3C – Rest home IV 3D – ICF geriatric III 3E – SNF geriatric II 3F – SNF-Medicare 3L – SNF pediatric II 3M – SNF psychiatric II 3R – ICF/MR type B 3S – ICF/MR type C 3U – SNF-Medicare I/II
19	Dates of Service: From/To	Enter the beginning and end date the service was provided in MMDDYY format. Submit claims for services furnished during one calendar month on one claim line. Do not bill for more than one month on the same claim line.
20	No. of Days	Enter the total number of days of care represented by the "From" and "To" dates entered in Item 19. If the member is not discharged during the billing period, the total days of care are from the first day of the billing period to the last. Do not count the day of discharge or death as a day of care unless it was also the day of admission.

Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
21	Patient Status	Enter the code from the list below that describes the status of the member. 01 – Discharged to home or self-care (routine discharge) 02 – Discharged to acute inpatient hospital (short-term) 03 – Discharged to skilled nursing facility (SNF) 04 – Discharged to intermediate care facility (ICF) 06 – Discharged to home under care of home health agency 07 – Left against medical advice 10 – Discharged to chronic/rehabilitation hospital 11 – Discharged to psychiatric inpatient hospital 12 – Discharged to rest home 13 – Discharged to community ICF/MR 14 – Discharged to state school ICF/MR 15 – Discharged to community residence 21 – Deceased 30 – Still a patient 34 – Still a patient—transferred to another level of care facility 35 – Still a patient—on leave of absence 99 – Other
22	Rate	Enter the rate established by the Division of Health Care Finance and Policy.
23	Total Charge	Enter the facility's total charge by multiplying the amount entered in Item 22 by Item 20.
24	Patient Pd. Amount	Enter the amount of the member's monthly income that has been predetermined to be paid toward the cost of care.
25	Other Pd. Amount	Leave this item blank unless the member has other health insurance coverage. Do not enter previous MassHealth payments. Enter any amount received for the service from any source other than MassHealth, and attach to the claim form a copy of the notice of final disposition from the other payment source. This notice may be an explanation of benefits (EOB) or a remittance advice. Any amount entered in Item 25 will be deducted from the MassHealth payment.
26	Net Charge	Enter the amount that is left after subtracting Item 24 and Item 25 from Item 23.

Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
27	Medical Leave of Absence	Enter the period(s) of medical leave of absence (MLOA) for acute hospital stays in MMDDYY format. Up to three occurrences of MLOA can be entered on one claim line. Additional occurrences must be entered on a new claim line. MLOAs that span two calendar months must be entered on two separate lines. *From:* Enter the date the member left the facility. *To:* Enter the last full date of the member's absence. *No. of Days:* Enter the total number of MLOA days represented by the "From" and "To" dates.
28	Nonmedical Leave of Absence	Enter the period(s) of nonmedical leave of absence (NMLOA) in MMDDYY format. Up to three occurrences of NMLOA can be entered on one claim line. Additional occurrences must be entered on a new claim line. NMLOAs that span two calendar months must be entered on two separate lines. *From:* Enter the date the member left the facility. *To:* Enter the last full date of the member's absence. *No. of Days:* Enter the total number of NMLOA days represented by the "From" and "To" dates.
29	Office Use Only	Leave this item blank.
30	Authorized Signature	The claim form must be signed by the provider or by an individual designated by the provider to certify that the information entered on the form is correct. Signatures other than handwritten signatures (for example, stamped, typewritten, or mechanically applied) are acceptable.
31	Billing Date	Enter in MMDDYY format the date on which the claim form was completed. This date cannot be before the last date of service on the form.

Item-by-Item Instructions for Claim Form No. 10 (cont.)

Item No.	Item Name	Description
32	Adjustment/Resubmittal	If the claim is an adjustment or resubmittal, check the appropriate box. Use the resubmittal option for certain previously denied claims over 90 days. Do not make any entry in this item without completing Item 33. For additional information about correcting claims, consult Subchapter 5 of your MassHealth provider manual.
33	Former Transaction Control No.	When an entry is required in this item, enter the 10-character transaction control number (TCN) assigned to the original claim. The TCN appears on the remittance advice that listed the original claim as paid or denied. This item is required if either of the boxes in Item 32 are checked. Refer to Part 7 of Subchapter 5 of your MassHealth provider manual before attempting to resubmit or adjust claims. Incorrect use of the TCN may result in denied claims.